AN ACT relating to health facility-acquired infections.
Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

For the purposes of Sections 1 to 4 of this Act:

(1) "Health facility" means an acute or critical care hospital, rehabilitation or surgical center, nursing facility, or ambulatory care center;

(2) "Health facility-acquired infection" or “HAI” means a localized or systemic condition that:

(a) Results from an adverse reaction to the presence of an infectious agent(s) or its toxin(s).

(b) There must be no evidence that the infection was present or incubating at the time of admission to the acute care setting, unless the infection was related to a previous admission to the same facility.

(3) "Multi-drug resistant organism" or "MDRO," means any bacterium resistant to three (3) or more classes of antibiotics AND including methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterocci (VRE), Clostridum Difficile, Enterobactriaceae, Acinetobacter, ceftazidime-resistant Klebsiella, and gram negative bacilli (GNB) or other organisms identified by the federal Centers for Disease Control and Prevention or Kentucky Cabinet of Health and Family Services as a multidrug resistant organism.

(4) “ Secretary” means the Kentucky Secretary of Health and Family Services or the Secretary who oversees the Kentucky Department for Public Health.

SECTION 2. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

The General Assembly finds and declares that:

(1) Over 1.7 million patients in the nation become infected after entering hospitals (let alone other health facilities) each year and about one hundred thousand (100,000) die as a result of those infections; In Kentucky, it is estimated that 23,000 patients are afflicted with hospital acquired infections with almost 1,400 deaths each year;

(2) Thomas R. Frieden, Director of the CDC (Centers for Disease Control and Prevention), has stated “Evidence indicates that, with focused efforts, these once formidable infections can be greatly reduced in number, leading to a new normal for healthcare-associated infections as rare, unacceptable events”;

(3) The CDC estimates the nationwide cost to treat hospitalized patients infected with HAI is between 28 to 33 billion dollars, and the increase in cost for Ventilator Associated Pneumonia, Surgical Site Infections and Catheter Associated Bloodstream Infections is between $28,404 to $34,670 per patient; AHRQ estimates that the average increase in cost for each HAI is $43,000 per patient;

(4) The federal Centers for Disease Control and Prevention reports that the number of cases of health facility-acquired infections exceeds the number of cases of any other reportable disease, and more deaths are associated with health facility- acquired infection than several of the top ten (10) leading causes of death reported in the United States;

(5) The CDC (Centers for Disease Control and Prevention), APIC (Association for

Professionals in Infection Control and Epidemiology), SHEA (Society for Healthcare Epidemiology of America), IDSA (Infectious Diseases Society of America), and CSTE (Council of State and Territorial Epidemiologists) have reaffirmed the importance of public reporting in a recent white paper which states: “The combined tools of healthcare payment, oversight and accreditation, and public reporting are emerging ways to increase adherence to HAI prevention practices”;

(6) The director of the CDC's HAI prevention program, Dr. Arjun Srinivasan, recently stated that the, “CDC does believe that increased transparency, public reporting of healthcare-associated infections is an important part of a comprehensive effort to prevent healthcare-associated infections and eliminate these infections and we are working very closely with states that either have laws or are considering laws to help them implement these.”

(7) Donald Wright, Deputy Assistant Secretary for Healthcare Quality, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services has stated the following: “State initiatives on public reporting of healthcare-associated infections play an important role in the Federal effort to prevent healthcare-associated infections”;

(8) The Centers for Disease Control and Prevention’s National Healthcare Safety Network and the Agency for Healthcare Research and Quality’s Patient Safety Organization Network of Patient Safety Databases, facilitates the collecting and reporting of standardized data on healthcare-associated infections. These systems are in increasingly common use by healthcare providers and facilities and by State health agencies;

(9) Virtually all published analyses that compare the cost of screening patients upon admission and the adoption of effective infection control practices with the cost of caring for infected patients conclude that caring for infected patients is much more expensive;

(10) Multidrug resistant infections are preventable, and recent data support a multifaceted approach to successfully combat infections, including routine screening, isolation of colonized and infected patients, strict compliance with hygiene guidelines, and a change in the institutional culture to ensure that infection prevention and control is everyone's job and is a natural component of care at each patient encounter each day;

(11) The Association for Professionals in Infection Control and Epidemiology report that the incidence of Clostridum Difficile is increasing more than 10 times as expected, and the American Journal of Infection Control reports that Kentucky has the sixth highest rate of infection in the United States;

(12) Methicillin-resistant staphylococcus areus (MRSA) is a common staphylococcal infection that is resistant to powerful antimicrobial agents and is increasingly prevalent in health care settings;

(13) Because it can survive on cloth and plastic for up to ninety (90) days, MRSA is frequently transmitted by contaminated hands, clothes, and noninvasive instruments and the number of patients who can become infected from one (1) carrier multiplies dramatically;

(14) The federal Centers for Disease Control and Prevention estimates that one (1) in twenty (20) patients entering a health facility carries MRSA and reports that MRSA accounts for sixty percent (60%) of infections in American hospitals in 2004, an increase from two percent (2%) in 1974, and currently increasing, in 2007 the Association for Professionals in Infection Control and Epidemiology reported that the prevalence of MRSA was increasing eight times more than

expected;

(15) Routine screening and isolation of all patients with MRSA in hospitals has produced the following results:
(a) Denmark and Holland have reduced their MRSA infection rate to ten percent (10%) of their bacterial infections and,
(b) following a pilot program by the United States Department of Veterans Affairs' Pittsburgh Healthcare System that reduced MRSA infections in its surgical care unit by seventy percent (70%), all Department of Veterans Affairs health facilities have implemented similar procedures and,
(c) national data obtained from the Department of Veterans Affairs by congressional inquiry found an MRSA infection reduction of 76% in the ICU setting and a 28% reduction in the non-ICU setting after implementation of similar procedures and,
(d) Northwest University reported that the aggregate hospital-associated MRSA disease prevalence density decreased by 69.6% after universal surveillance was instituted;

(16) It is a matter of public health and fiscal policy that patients in Kentucky's health facilities receive health care that incorporates best practices in infection control, not only to protect their health and their lives, but also to ensure the economic viability of Kentucky's health facilities.

SECTION 3. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) Within ninety (90) days of the effective date of this Act, all health facilities shall review existing plans and implement a comprehensive infection prevention program which adheres to evidence based practices that at least includes intensive care units, surgical units, or other units or areas where there is a significant risk of health facility-acquired infection. By January 1, 2011, each health facility's infection prevention program shall be implemented throughout the facility.

(2) As a condition of licensure, a health facility shall implement best practices and effective strategies for an infection prevention program in accordance with subsection (1) of this section and implement best practices for preventing MDROs and other pathogens as the Secretary determines appropriate that include but are not limited to:
(a) Contact precautions as specified by the federal Centers for Disease Control and Prevention for patients found to be positive for MDROs;
(b) Strict adherence to hygiene guidelines that include but are not limited to health facility staff hand washing prior to and after patient contact;
(c) The use of procedure checklists that have been shown to reduce the incidence of HAI;
(d) The development of a written infection prevention and control policy with input from front-line caregivers, and the posting of public notices regarding the infection prevention and control policy; and
(e) A worker and staff education requirement regarding modes of transmission of MDROs, use of protective equipment, disinfection policies and procedures, and other preventive measures.

(3) Surveillance Cultures:

(a) Not later than 90 days after the date of enactment of this Act, each acute care hospital shall screen for MRSA infections, and such other MDRO pathogens as the Secretary deems necessary, for each patient entering an intensive care unit or other high-risk hospital department (as defined by the Secretary).

(b) The Secretary, consulting guidelines established by the Centers for Disease Control and Prevention, shall establish a process and a timetable for extending the screening requirements of Section 3 (3)(a) of this Act to all patients admitted to a health facility or discharged from an acute or critical care hospital, or nursing facility not later than January 1, 2012.

(c) The Secretary may waive the requirements of Section 3 (3), if the Secretary determines, consulting guidelines established by the Centers for Disease Control and Prevention and after public hearing, that the rate of MRSA infections or other infections has declined to a level at which further screening is no longer needed.

(4) The Cabinet for Health and Family Services shall make data available on its website at least annually in understandable language with sufficient explanations to allow consumers to draw meaningful comparisons between health facilities as relevant data becomes available. Data shall include but not be limited to:

(a) The facility's rate of health facility-acquired infections;
(b) The rate of health facility-acquired MDRO infections; and
(c) The total number of MDRO infections found on surveillance cultures on admission.
(d) The rate of positive conversions of discharge cultures at acute and critical care hospitals, and nursing facilities.

(5) Health facilities shall use the Centers for Disease Control and Prevention's NHSN (National Healthcare Safety Network) reporting system or other data collection method as determined by the Secretary for implementation of this Act.

(6) The Secretary shall by July 1, 2011 implement a method for patients to HAI to verify the data reported by health facilities.

(7) The Secretary of the Cabinet for Health and Family Services shall serve as chief administrative officer for the health data collection functions of this Act. Neither the Secretary nor any employee of the cabinet shall be subject to any personal liability for any loss sustained or damage suffered on account of any action or inaction related to this Act.

(8) The Secretary of the Cabinet for Health and Family Services shall report by each January 30th to the Legislative Research Commission and the Governor on the rate and trend of health facility-acquired infections, the effectiveness of the requirements of Sections 1 to 4 of this Act on reducing the rate of health facility-acquired infections and recommendations for improvement.

SECTION 4. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

A health facility that violates any provision of Section 3 of this Act shall for the first violation within a six-month period, be cited and shall submit a corrective action plan within ten (10) business days of the citation. For a second violation, within a six-month period, a health facility shall be fined up to one thousand dollars ($1,000) per day until the violation is corrected. For three or more violations within a six-month period, a health facility shall be fined up to $10,000 for each violation and shall be fined up to two thousand dollars ($2,000) per day until all violations are corrected.